Public Document Pack

Agenda

Public Health Dorset

Meeting: Joint Public Health Board

Time: 10.00 am

Date: 21 November 2016

Venue: Committee Suite,

Civic Centre, Borough of Poole, Poole , BH15 2RU,

Bournemouth Borough Council	Dorset County Council	Borough of Poole
Nicola Greene	Jill Haynes	Drew Mellor
Jane Kelly	Rebecca Knox	Karen Rampton
Reserve Members:		
Blair Crawford	Colin Jamieson	Mike White
David D'Orton-Gibson (Observer)	Janet Dover (Observer)	Vacancy (Observer)

Notes:

- The reports with this agenda are available at www.dorsetforyou.com/countycommittees then click on the link "minutes, agendas and reports". Reports are normally available on this website within two working days of the agenda being sent out.

- We can provide this agenda and the reports as audio tape, CD, large print, Braille, or alternative languages on request.

- **Public Participation**

  Guidance on public participation at County Council meetings is available on request or at http://www.dorsetforyou.com/374629.

  Public Speaking

  Members of the public can ask questions and make statements at the meeting. The closing date for us to receive questions is 10.00am on 16 November 2016, and statements by midday the day before the meeting.

Debbie Ward
Chief Executive

Contact: David.Northover
County Hall, Dorchester, DT1 1XJ
d.r.northover@dorsetcc.gov.uk

Date of Publication:
Friday, 11 November 2016

Bournemouth, Poole and Dorset councils working together to improve and protect health

1. **Chairman**

To elect a Chairman for the meeting. (It was agreed at the previous meeting that the Chairmanship would rotate amongst the three authorities and that the Vice-Chairman identified at a meeting would become the Chairman at the following meeting).

2. **Vice-Chairman**

To appoint a Vice-Chairman for the meeting.

3. **Apologies**

To receive any apologies for absence.

4. **Code of Conduct**

Members are required to comply with the requirements of the Localism Act 2011 regarding discosable pecuniary interests and you should therefore:

- Check if there is an item of business on this agenda in which you or a relevant person has a disclosable pecuniary interest.
- Inform the Secretary of the Group in advance about your disclosable pecuniary interest and if necessary take advice.
- Check that you have notified your interest to your own Council's Monitoring Officer (in writing) and that it has been entered in your Council's Register (if not this must be done within 28 days.
- Disclose the interest at the meeting and in the absence of a dispensation to speak and/or vote, withdraw from any consideration of the item.

Each Council's Register of Interests is available on their individual websites.

5. **Minutes** 5 - 18

To confirm the minutes of the meeting held on 19 September 2016 (attached).

6. **Public Participation**

To consider any requests for public speaking.

7. **Forward Plan of Key Decisions** 19 - 22

The Board's Forward Plan identifies Key Decisions to be taken by the Board and items that are planned to be considered in a private part of the meeting. The current Forward Plan was published on 24 October 2016 and includes items that will be considered either on or following the Board's meeting on 21 November 2016 (attached).The next Forward Plan will include items to be considered on or following the Board meeting on Monday 6 February 2017 and will be published on 6 January 2017 and what is due to be considered at that meeting is indicated too.

8. **Public Health Dorset business plan developments** 23 - 30

To consider a report by the Director of Public Health (attached).

9. **Public Health Finances** 31 - 46

To consider a report by the Director of Public Health and Chief Financial Officer (attached).

10. **Integrated Community Services part of the Sustainability Transformation Plan (STP)** 47 - 52

To consider a report by the Director of Public Health (attached).

11. **Air pollution and its impact on health locally**

To receive a PowerPoint presentation by the Director of Public Health.

12. **Questions from Councillors**

To answer any questions received in writing by the Chief Executive by not later than 10.00am on Wednesday 16 November 2016.

This page is intentionally left blank

Joint Public Health Board

Minutes of the meeting held at County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ on Monday, 19 September 2016

Present:
Rebecca Knox (Chairman)
Jill Haynes, Drew Mellor, Nicola Greene and Jane Kelly

Members Attending
David Harris, Dorset County Council

Officers Attending: Sam Crowe (Assistant Director of Public Health - Bournemouth), Jane Horne (Consultant in Public Health), David Phillips (Director of Public Health), Rachel Partridge (Assistant Director of Public Health), Sophia Callaghan (Assistant Director of Public Health - Poole), Helen Coombes (Interim Director for Adult and Community Services - Dorset), Katherine Harvey (Consultant), Jane Portman (Executive Director, Adults and Children - Bournemouth), Jan Thurgood (Strategic Director - People Theme - Poole), Clare White (Accountant - Dorset) and Fiona King (Senior Democratic Services Officer - Dorset).

(Note: These minutes have been prepared by officers as a record of the meeting and of any decisions reached. They are to be considered and confirmed at the next meeting of the Board to be held on **Monday, 21 November 2016**.)

Chairman

13 **Resolved**
That Councillor Rebecca Knox be elected Chairman for the meeting, in accordance with the Board's procedures.

Vice- Chairman

14 **Resolved**
That Councillor Drew Mellor be appointed as Vice-Chairman for the meeting.

Apologies

15 An apology for absence was received from Karen Rampton, Borough of Poole.

Code of Conduct

16 There were no declarations by members of disclosable pecuniary interests under the Code of Conduct.

Minutes

17 **Resolved**
That the minutes of the meeting held on 6 June 2016 be confirmed and signed subject to two amendments in Minute 8:-

- Paragraph 3, replace 'netter' with better; and
- Paragraph 4, second bullet point amend to read 'Prevention at Scale'.

Matter Arising
Minute12 – Questions
The Director of Public Health advised that the series of briefing notes would be prepared in readiness for the next meeting of the Board in November.

Public Participation

18 There were no public questions or statements received and no requests to present

petitions.

Forward Plan of Key Decisions

19 The Board considered its Forward Plan, which identified key decisions to be taken by the Board at future meetings.

The Director of Public Health suggested additional topics for November, namely:

- More detailed discussion of commissioning intentions for drugs and alcohol, sexual health and health visiting & school nursing.
- The Director of Public Health annual report.
- Air pollution and its impact on health locally.
- Integrated community services part of the Sustainability Transformation Plan (STP).

Resolved

That the Forward Plan be agreed.

National and International Advances in Public Health

20 The Board received a presentation from the Director of Public Health, appended to these minutes for ease of reference.

The Director felt it would be helpful for members to have sight of the 'outside world' in respect of National and International Health.

Following a question from a member from Bournemouth Borough Council regarding the figures displayed in the communicable diseases section, the Director advised they were world-wide figures.

It was highlighted that the drivers for many communicable disease outbreaks were often changes in population & land use and ease of travel.

The Director highlighted the Childhood Obesity Strategy and questioned whether this needed to be accelerated locally. The Cabinet Member for Adult Social Care, Dorset County Council, felt it was important to get children doing things they used to do and not just participating in organised sport.

The Chairman highlighted that the Dorset Physical Activity Strategy was due to be presented to the Dorset Health and Wellbeing Board at their next meeting on 9 November 2016.

Noted

Developing prevention at scale

21 The Board received a report by the Director of Public Health which gave members an update on the work to develop the Prevention at Scale (PAS) programme within the Sustainability and Transformation Plan (STP) for Dorset.

The Assistant Director of Public Health, Bournemouth, summarised some of the work that had developed over the summer months. Officers were working to develop a common story of what prevention at scale would look like.

Included within the report was a presentation which described the context for closing the Health and Wellbeing gap and rationale for Prevention at Scale within the STP. It also illustrated the challenge in Dorset in regard to one of the agreed priorities; i.e. Diabetes and Cardiovascular disease (CVD), along with some ideas about how to move forward.

The differential performances across the County in the management of these conditions between localities and practices were highlighted and members felt that the Health and Wellbeing Boards needed to focus on this.

In response to a question from the Chairman the CCG were in discussions about the variations. In respect of the top performing practices, the Cabinet Member for Adult Social Care, Dorset County Council, questioned whether these practices were contacting patients to offer the services and therefore showing better figures. The Director drew members' attention to a slide which showed a significant number of people were undiagnosed and that an approach based on just finding cases would not be successful due to the scale of the challenge. He illustrated how significant savings might be made to both the NHS and Local Authorities if some of these variations were improved.

Following discussion, members agreed the recommendation as set out below.

Resolved
That the members of the Joint Public Health Board noted the variation between one area and another and that this be taken forward to the seminar on Prevention at Scale on 21 October 2016 and that it also be part of the Health and Wellbeing agenda.

Public Health Dorset business plan developments

22 The Board received a report by the Director of Public Health updating members on developments for Public Health Dorset's business plan 2016-18 in the past quarter.

The Deputy Director of Public Health highlighted some key areas and noted that lengthy discussions had followed as result of a number of service reviews on drugs and alcohol which had now been agreed by the Pan-Dorset Drug and Alcohol Governance Board.

In respect of the NHS Health Checks programme, the Assistant Director confirmed that Boots provided most of the health checks for Poole, Purbeck, North Dorset and the three Bournemouth localities, the other areas of the County were provided by GPs. There were clusters of GPs working together to provide this service on a locality basis. The checks were offered on an open invitation process but it was found that the people who tended to take them up were from the low risk group.

The Assistant Director of Public Health updated members on the outbreak of measles locally, and advised that the numbers had stabilised and since May 2016 there had been 10 confirmed cases. She felt this was a good opportunity to remind parents and young people about their vaccination status.

Resolved
1. That members noted the progress made against the work plan priorities.
2. That the recommended set of treatment target groups, which would underpin the ongoing work to develop future service model options for drug and alcohol services be approved.

Reason for Decisions
To ensure the continued viability and effectiveness of Public Health Dorset in supporting the legal duty of local authorities in Dorset to improve the health and wellbeing of residents and reduce inequalities in health.

Financial Report to end July 2016/17

23 The Board considered a joint report by the Chief Financial Officer and Director of Public Health which updated members on the forecast for 2016/17. This identified indicative savings of approximately £1.2m in 2016/17 and 2017/18 and a current reserve of £2.3m. It was highlighted that the reserve had been held to mitigate any

risks arising from volatility in a) budget changes from the Department of Health (DoH) announced last year and b) cost and volume contracts. The report identified that there was much more stability in these areas and suggested it may be timely to consider redeploying some of these monies to priority areas better reflecting recent developments.

The priority areas which were prescribed by the DoH in the ring fenced grant were described and significantly how many of these were integral to the Prevention at Scale approach in the STP. It was suggested that the reserve in principle be moved to a PAS 'account' that would be enable projects to be developed by the respective Health and Wellbeing Boards to respond to the agreed STP plan. The Chairman reinforced that the monies were ringfenced and there were specific criteria where the monies could be spent.

Members from Bournemouth Borough Council advised that they had been given clear advice by their Section 151 Officer to reconsider these recommendations and to look to return the reserve to the respective authorities accounts.

The Vice-Chairman noted the advice from his Section 151 Officer was to have ultimate security of the money and for the reserve to go back to that authority (Borough of Poole). With regards to the in-year saving, he questioned whether that could be used for any business cases that came forward.

The Director advised that there were real challenges and risks in transferring monies back to general funds whilst reducing the funding of mandatory services many of which were provided by the NHS. He indicated that this was an outline proposal about how we might best use the grant to address priority population health outcomes in line with DoH guidance on the use of the grant.

The Chairman felt that more clarity was needed; the Cabinet Member for Adult Social Care was concerned that other members had received advice from their Section 151 Officers and proposed that the Board accepted the first part of the recommendation but to then bring a report back to the November 2016 meeting following discussions with Section 151 Officers and others.

Cllr Greene from Bournemouth Borough Council seconded the proposal and noted that November 2016 would still be in time in terms of internal budget setting and agreed it would be important to get other partners involved and see what they could bring to the table.

Resolved
That the current budget position be noted and that following discussion with Section 151 Officers a further report be considered at the meeting in November 2016.

Reason for Decision
Close monitoring of the budget position was an essential requirement to ensure that money and resources were used efficiently and effectively and in line with grant criteria.

Questions from Councillors

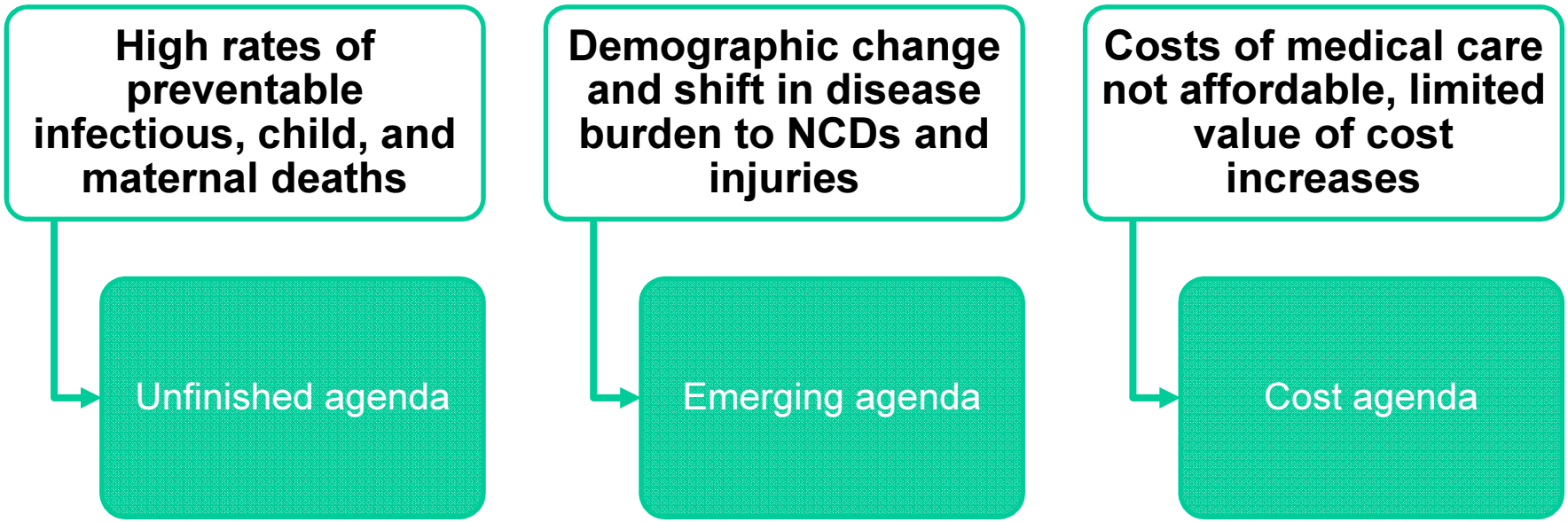
24 No questions were asked by members under Standing Order 20(2).

Meeting Duration: 10.00 am - 12.10 pm

National and International Public Health

A Brief Update

2015-2035: Three Domains of Health Challenges



Domain One: Communicable Disease Pandemics

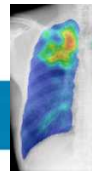
(in comparison with WW2)

	Black Death	WW2	Spanish Flu	Swine Flu	Seasonal Flu	Ebola	Measles	T
)	1346-53	1939-45	1918-19	2009	Yearly	2014-15	Ongoing	Ongo
on(s)	Europe, N Africa	Europe, N Africa, N America	Europe, Asia, N.America	Worldwide	Worldwide	West Africa	Worldwide	Worl
s	100 million	50-80 million	50 million	284,000	250-500,000	11,310	114, 900 (2014)	1.49 (201









Ebola

Total of 28,616 cases since July 2014 [West Africa]

10,000 survivors, 11,301 deaths

March 2016- public health emergency status lifted

June 2016- end of virus transmission in Guinea and Liberia

Note: lucky a) didn't make to Port Harcourt and

b) very poor human to human transmission.

Zika virus

- Vector borne virus – Aedes aegypti [dengue, yellow fever]
- 67 countries have reported Zika virus since 2015
- 17 countries have reported microcephaly associated with Zika virus

Why and what does it mean for us?

- Poverty, urbanisation & population growth and travel [first Ebola outbreak was 1976]

- Encroaching onto animal's ‘territory’

UK

- Increase in rates of lyme disease and Brucella in UK, similarly pressure on arable land has driven campylobacter rates

- Are our national systems up to it – see recent commons select committee report

Global

- Lot of other organisms as bad as Ebola out there Hanta virus, Lassa fever, which to date have only caused localised outbreaks.

Domain Two: NCDs – Childhood Obesity Strategy

Challenge includes marketing messages- be ‘happy’ in charge of ‘own choices’

‘Start of a conversation not the final word’

Schools – food standards; physical activity - ? Focus on earlier years?

Previously announced levy on sugar content of drinks

Voluntary reformulation; marketing and price promotion not touched

2011 – PH Responsibility deal – little impact

Do we need to accelerate ‘conversation’ locally?

Domain Three: Select Committee Review of PH post 2013 Conclusions & Recommendations

Funding

Cuts to public health are a false economy. Further cuts to public health will threaten the future sustainability of NHS services if we fail to manage demand from preventable ill health.

We recommend that the Government sets out how changes to local government funding and the removal of ring fencing will be managed

Systematically improving public health and addressing unnecessary variation

The Government should set out clear milestones of what it expects public health spending to achieve, and by when.

Politics and evidence

Benchmarking standards for all local authorities' prescribed public health functions should be introduced, and provide reassurance that these functions are being maintained at an appropriate level.

Leadership for public health at a national level

Since Public Health England was established, the interface between it and the DH has lacked clarity.

We urge NHS England and PHE to clarify how the two organisations resources around public health support the local health system and not confuse it.

Access to data

Our inquiry has identified numerous problems with access to data for public health professionals, which is creating barriers to effective joint working.

Select Committee Review of PH post 2013 Conclusions & Recommendations II

The public health workforce

This is particularly important given the potential impact of reduced spending by councils on public health staffing.

Barriers to workforce mobility must be removed, we are concerned that this issue has not been resolved three years after the transfer of public health responsibility to local authorities.

Health protection

More work needs to be done at a national level to support local areas to deliver a seamless and effective response to outbreaks and other health protection incidents.

Health in all policies

We urge the Government to good on its commitment to health in all policies, by enshrining health as a material consideration in planning and licensing law.

The role of the NHS in public health

The system of enhanced public health accountability must be extended into the NHS, forming part of a broader national strategy to systematically and demonstrably implement the radical upgrade in public health called for in the Five Year Forward View.

The NHS has an important role to play in prevention, and developing the skills of its workforce to deliver preventative advice as part of routine care is central to that.

Comments

- States some issues which are ongoing for three years but omits some systemic issues; fails to provide level of analysis to inform next steps.
- Report relies too heavily on individual commentary and too little on any independent review
- Rhetoric++ but reality is we have been here before…..
- Working with PHE to look at ‘one service’ with clear division of functions, tasks and skills.
- Same discussion about LGR – what functions are best performed at what population level etc.

Dorset County Council

DRAFT – Joint Public Health Board Forward Plan
(Next Public Health Joint Board Meeting Date – 21 November 2016)
(Publication date – 21 October 2016)

Explanatory note: This work plan contains future items to be considered by the Joint Public Health Board. It will be published 28 days before the next meeting of the Board.

This plan includes key decisions to be taken by the Board and items that are planned to be considered in a private part of the meeting. Key decisions are indicated by the following symbol:

The plan shows the following details for key decisions:-

(1) date on which decision will be made
(2) matter for decision, whether in public or private (if private see the extract from the Local Government Act on the last page of this plan)
(3) decision maker
(4) consultees
(5) means of consultation carried out
(6) documents relied upon in making the decision

Any additional items added to the Forward Plan following publication of the Plan in accordance with section 5 of Part 2, 10 of Part 3, and Section 11 of Part 3 of The Local Authorities (Executive Arrangements) (Meetings and Access to information) (England) Regulations 2012 are detailed at the end of this document.

Definition of Key Decisions
Key decisions are defined in the County Council's Constitution as decisions of the Board which are likely to -

"(a) result in the County Council incurring expenditure which is, or the making of savings which are, significant having regard to the County Council's budget for the service or function to which the decision relates namely where the sum involved would exceed £500,000; or

(b) to be significant in terms of its effects on communities living or working in an area comprising two or more electoral divisions in Dorset."

Membership of the Board

Bournemouth Borough Council	Dorset County Council	Borough of Poole
Nicola Greene	Jill Haynes	Drew Mellor
Jane Kelly	Rebecca Knox	Karen Rampton

How to request access to details of documents, or make representations regarding a particular item
If you would like to request access to details of documents or to make representations about any matter in respect of which a decision is to be made, please contact the Principal Democratic Services Officer, Corporate Resources Directorate, County Hall, Colliton Park, Dorchester, DT1 1XJ (Tel: (01305) 224187 or email: d.r.northover@dorsetcc.gov.uk).

Date of meeting of the Joint Committee (1)	Matter for Decision/ Consideration (2)	Decision Maker (3)	Consultees (4)	Means of Consultation (5)	Documents (6)
21 Nov 2016	 **2016/17 Delivery Commissioning & Performance Indicators** Director for Public Health Report	Joint Public Health Board	Internal and other LA Dept Multiple Agencies. Public and Voluntary Sectors	Structured & informal consultation processes	Board Report
21 Nov 2016	 **Commissioning intentions for drugs and alcohol, sexual health and health visiting & school nursing** Director for Public Health Report	Joint Public Health Board	Internal and other LA Dept Multiple Agencies. Public and Voluntary Sectors	Structured & informal consultation processes	Board Report
21 Nov 2016	 **Public Health Finances** Chief Financial Officer's Report	Joint Public Health Board	Internal and other LA Dept Multiple Agencies. Public and Voluntary Sectors	Structured & informal consultation processes	Board Report

21 Nov 2016	**Director of Public Health's annual report**	Joint Public Health Board	Internal and other LA Dept Multiple Agencies. Public and Voluntary Sectors	Structured & informal consultation processes	Board Report
21 Nov 2016	**Air pollution and its impact on health locally** Director for Public Health Report	Joint Public Health Board	Internal and other LA Dept Multiple Agencies. Public and Voluntary Sectors	Structured & informal consultation processes	Board Report
21 Nov 2016	**Integrated community services part of the Sustainability Transformation Plan (STP)** Director for Public Health Report	Joint Public Health Board	Internal and other LA Dept Multiple Agencies. Public and Voluntary Sectors	Structured & informal consultation processes	Board Report

The following paragraphs define the reasons why the public may be excluded from meetings whenever it is likely in view of the nature of the business to be transacted or the nature of the proceedings that exempt information would be disclosed and the public interest in withholding the information outweighs the public interest in disclosing the information to the public. Each item in the plan above marked as 'private' will refer to one of the following paragraphs.

1. Information relating to any individual.
2. Information which is likely to reveal the identity of an individual.
3. Information relating to the financial or business affairs of any particular person (including the authority holding that information).
4. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under, the authority.
5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings.
6. Information which reveals that the authority proposes:-
   (a) to give under any enactment a notice under or by virtue of which requirements are imposed on a person; or
   (b) to make an order or direction under any enactment.
7. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

Business not included in the Board Forward Plan

Is this item a Key Decision	Date of meeting of the Joint Committee meeting	Matter for Decision/ Consideration	Agreement to Exception, Urgency or Private Item	Reason(s) why the item was not included
		NONE		

The above notice provides information required by The Local Authorities (Executive Arrangements) (Meetings and Access to information) (England) Regulations 2012 in respect of matters considered by the Cabinet which were not included in the published Forward Plan.

Agenda Item 8

Public Health Dorset

Agenda Item:

Insert Item No.

Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	21ST November 2016
Officer	Director of Public Health
Subject of Report	**Public Health Dorset business plan developments**
Executive Summary	This report presents an update on developments for Public Health Dorset's business plan 2016-18 since September. This includes progress of commissioning models, priorities and proposed future contract values.
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: N/A
	Use of Evidence: Public Health Dorset routinely uses a range of evidence to support the development of business plans and priorities as part of its core business.
	Budget: The report contains information about Public Health Dorset's progress against the stated intention to release further savings from the Public Health Grant over the next two financial years. This report focuses on re-commissioning of drug and alcohol, children's 0-5 services and sexual health services.

	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: MEDIUM Residual Risk MEDIUM *(i.e. reflecting the recommendations in this report and mitigating actions proposed)*
	Other Implications: N/A
Recommendations Summary	Members of the Joint Public Health Board are asked to: 1) Comment on proposals of the three work plan priorities. 2) Agree the budget allocation, joint commissioning intentions, arrangements and timelines
Reason for Recommendation	To ensure the continued viability and effectiveness of Public Health Dorset in supporting the legal duty of local authorities in Dorset to improve the health and wellbeing of residents and reduce inequalities in health.
Appendices	
Background Papers	None.
Report Originator Contact	Name: Sophia Callaghan, Kate Harvey, Nicky Cleave Email: s.callaghan@dorsetcc.gov.uk

Director's name: Dr David Phillips
Director of Public Health
November 2016

1. Recommendations

1.1 Members of the Joint Public Health Board are asked to note the progress with the business plan 2016-18, particularly the ambitions for releasing further savings from the public health functions through re-commissioning.

1.2 For drug and alcohol services, the Joint Public Health Board is asked to comment on the proposals for the development of a future system design for substance misuse treatment and in doing, advise commissioners of any potential opportunities or challenges they envisage given their specific perspectives and expertise.

1.3 For sexual health services, the Joint Public Health Board is asked to agree the budget allocation for sexual health services for 2017/18 and 2018/19 and agree the Joint commissioning arrangements and timeline between Public Health and Dorset CCG.

1.4 For health visiting and school nursing, the Joint Public Health Board is asked to agree Health visiting commissioning intentions for 2017/18 and timelines for procurement or potential changes in primary commissioner. The Board is asked to note that key decisions on the commissioning model and investment will be required at the next meeting in February 2017.

2. Reason

2.1 To ensure the continued viability and effectiveness of Public Health Dorset in supporting the legal duty of local authorities in Dorset to improve the health and wellbeing of residents and reduce inequalities in health. To identify and release further savings to be re-invested by Local Authorities in Dorset in priority outcomes including early intervention and health protection.

2.2 This report sets out progress since the September Board meeting against the objectives for clinical treatment and health improvement services for Health Visiting and School Nursing in the business plan.

Clinical Treatment Services

3. Drug and Alcohol Services

Background

3.1 Prior to 2013, under the National Treatment Agency (NTA), funding for adult drug treatment was allocated for each local authority area based on estimated need, combined with activity and performance of existing services.[1] At this point, funding allocations were frozen and incorporated into the Public Health grant to local authorities.

3.2 Based on these allocations, along with Public Health and local authority spend on adult and young people's treatment services, the total budget for substance misuse services across Bournemouth, Poole and Dorset was approximately £11.3m in 2013-14. The

[1] See http://www.nta.nhs.uk/funding.aspx for more information

budget for 2016/17 across the equivalent services is now £8.8m, representing a saving of approximately 22% since 2013-14.

3.3 In relation to the substance misuse contracts managed by Public Health Dorset the current budget in 2016/17 is £4.9m, which equates to a budget reduction of 16% or £1m since 2013/14 - this has been achieved by recommissioning of detoxification services, and improved efficiencies within existing contracts, but fundamentally the core offer to service users remains unchanged.

3.4 The contracts for a number of treatment services currently in place across the Pan-Dorset area will cease at the end of September 2017 and so decisions need to be made imminently about future commissioning arrangements. The contracts that come to an end include the entirety of the adult treatment services for Dorset which are managed by Public Health Dorset, as well as some services in Bournemouth. In Poole all services terminate on 31 March 2017, but procurement in Poole are satisfied that, if a re tendering process has commenced, new contracts can be let on the same time scale as Dorset where appropriate.

3.5 This offers an opportunity for services to be re-modelled to ensure that services are effective, and focused on delivering a cost-efficient service for the changing needs of service users, whilst also delivering the necessary savings to support the delivery of the reductions in Public Health allocations to the three local authorities by 2019/20.

Progress to date

3.6 At their last meeting in September 2016 the Board agreed to a recommendation from the Pan-Dorset Drug and Alcohol Governance Board to the adoption of a more targeted approach in service provision that makes the most efficient use of limited resources by identifying specific target groups and aiming for achievable outcomes tailored to the needs of the specific service user. The agreed target groups are summarised below.

Prevention / Treatment Target Groups	**Rationale**
• Young people (under18)	Fit with the broader early intervention agenda; ability to prevent more serious substance misuse and associated consequences
• Young adults (18-25)	More likely to achieve successful completion when previously untreated
• Parents and families	Costs of parental substance misuse both on children, and on social care costs;
• Pregnant women	Protection of the unborn child
• Risk of adult or children safeguarding issues	Statutory responsibility for LA, with associated costs

3.7 Based on these principles, a series of indicative offer levels was presented to the Pan-Dorset Joint Commissioning Board (JCB), each with different levels of service provision and associated savings from the current budget:

1. Indicative Minimum / Essential Service offer level
2. Indicative Low offer level
3. Indicative Medium offer level

4. Indicative High offer level (similar to current provision)

3.8 While Level 1 would require the lowest spend, it would also entail the lowest service offer and would present the highest risks to service users and the wider community. Service provision and investment costs increase through to Level 4, while the associated risks fall.

3.9 The JCB advised against taking forward either Level 1 or Level 4, instead recommending that further work be conducted on the 'Low' and 'Medium' offers to develop more concrete system and service designs. This approach was agreed with the Pan-Dorset Drug and Alcohol Governance Board at its meeting in October.

Proposed next steps

3.10 Extensive consultation with providers and users of local services as well as the wider public has already been conducted via online and paper surveys and face-to-face meetings as part of the service review completed earlier this year. The next stage of engagement is further events with wider stakeholders and potential providers at the end of November to develop a more detailed system design balancing the need for budget savings against the associated risks of negative impacts on performance across a range of outcomes including crime and antisocial behavior, physical harm, safeguarding, social care and successful completions.

3.11 Further consultation with service users and the wider public will then be conducted in light of feedback from these events and the development of a proposed service model.

3.12 The final proposed model for those substance misuse services managed by Public Health Dorset will be presented to the Board in February 2017 with the aim of commencing procurement at the end of March 2017.

3.13 It is acknowledged that the precise form of implementation of a more targeted approach to service provision in line with the principles already agreed may vary between local authority areas due to differences in local need and circumstances.

Recommendation

3.14 The Joint Public Health Board is asked to:

- Comment on the proposals for the development of a future system design for substance misuse treatment;
- Advise commissioners of any potential opportunities or challenges they envisage given their specific perspectives and expertise.

4. Sexual Health Services

4.1 Public Health Dorset set out a vision for a more integrated, efficient and effective sexual health delivery model in 2017 and simplify some of the commissioning complexities of the current system. To achieve this work is progressing to explore more collaborative approaches with the Clinical Commissioning Group (CCG) to better understand and agree the best way forward, for a more appropriate commissioning option for sexual health services.

Progress to date

4.2 At their last meeting, the Board agreed this approach in principle and requested a progress update with plans for commissioning over the next two years. Since this time, a joint commissioning options paper has been developed, which outlined the factors and rationale for change, budget responsibilities, financial considerations, and included the uncertainty of the future public health grant.

4.3 The options explored permutations of Public Health Dorset committing sums to the CCG, to configure and lead commissioning of sexual health services with Public Health support. This paper was submitted to the Clinical Commissioning Group Directors meeting in October 2016 and was approved to have joint arrangement with public health, which were established through a Section 75 agreement.

4.4 This would mean that budgets would be pooled or aligned and it was suggested that services would be jointly commissioned between Public Health and the CCG, who would be the lead commissioner. It was proposed that public health team members would still take responsibility jointly with the CCG team to commission services.

4.5 The benefits of this approach would mean that it would simplify commissioning processes, bring together the sexual health and HIV treatment and care budgets under one system and provide efficiencies and better value by nature of the arrangement.

4.6 In addition it could potentially reduce some of the instability of future funding and lock in the public health grant specifically related to sexual health through the Section 75 joint arrangement.

Commissioning plans and budget setting over the next two years

4.7 The sexual health contract value for 2016/17 has reduced by 6.2% from the 2014/15 outturn with a total budget value of £6,530,000. It is proposed that further savings take a phased approach with the 2017/18 contracts and the 2018/19 contracts be reduced by a further 6.9% each year. This would mean the budget available from 2018/19 onwards would be £5,512,000 and realises the planned 20% reduction from the 2015/16 baseline.

4.8 To ensure adequate time for finalising commissioning arrangements, current Dorset County Council Contracts will need to be extended with current terms, conditions and financial allocation until April 2017. The governance, accountability, degree of pooled budgets, contractual and legal arrangements can then be agreed with the CCG by April 2017. The new joint commissioning arrangements can commence from April 2017. The Section 75 joint arrangement could commence as an established agreement when responsibility for Specialised Commissioning Services for HIV treatment and Care return to the CCG from April 2018.

Recommendation

4.9 The Joint Public Health Board is asked to agree:

- The budget allocation for sexual health services for 2017/18 and 2018/19;
- Joint commissioning arrangements and timeline with Public Health and the CCG.

Health Improvement Function

5. Health Visiting and School Nursing

Commissioning Model

5.1 Health visiting and school nursing are commissioned on a pan-Dorset basis, with local variations in delivery within service specifications where required.

5.2 12 month contracts are being re-issued to Dorset HealthCare for 2017/18, with a requirement of the service to make changes to:

- Improve reporting of interventions and outcomes;
- Better align service delivery with local authority provision.

5.3 Decisions on the 2018 commissioning models will be brought to the next Joint Public Health Board in February, including deciding on the primary commissioner. Future re-commissioning of health visiting has been aligned with children's centre timelines, with new contracts in place for April 2018.

Future service models

5.4 A joint approach to commissioning is being taken with Local Authority colleagues in both the East (Bournemouth and Poole) and West (Dorset) to define future service models. The work programmes will be completed at the end of this year and have been designed to deliver:

- Equitable re-deployment of the health visiting service across teams that match Local Authority boundaries (workforce model complete December 2016, implementation April 2017);
- An aligned model of health visiting and children's centre service delivery, with a focus on effective high value activity and shared outcomes (January 2017);
- A more clearly defined school nursing model for the East and West in 2017/18, including defining the school nursing role within wider early intervention services.

5.5 Decisions on the 2018 commissioning models will be brought to the next Joint Public Health Board in February, including deciding on the primary commissioner. Future re-commissioning of health visiting has been aligned with children's centre timelines, with new contracts in place for April 2018.

Financial considerations

5.6 Since 2015/16, the health visiting and school nursing contract values have reduced by 6.2%. The 2016/17 contract values are £9,974,692 for health visiting and £1,215,903 for school nursing.

5.7 The 2017/18 contract will be reduced by a further 2.5%, with the allocation of an equivalent sum to a performance-related incentive payment tied to improving reporting on interventions and outcomes and alignment with local authority provision.

5.8 Appraisal of the options for 2018/19 health visiting and school nursing contract values will be brought to the next Joint Public Health Board meeting in February. This will include a review of the financial, service and risk implications. Parallel discussions in

each local authority are reviewing potential savings from children's centres and other early intervention services.

5.9 The Board is asked to note that savings beyond the planned reductions in the public health grant will have significant workforce implications and carry major political and reputational risk.

Recommendations

6.10 The Health Board is asked to agree the:

- Health visiting and school nursing commissioning intentions for 2017/18;
- Timelines for procurement and potential changes in primary commissioner.

6.11 The Board is asked to note the:

- Key decisions on the commissioning model and investment that will be required at the next meeting in February 2017;
- Discussions of strategic commissioning gaps for school aged children that are being raised with the Joint Commissioning Board.

7. Conclusion

7.1. This paper summarises progress since September against the main objectives of the Public Health Dorset business plan for re-commissioning of drug and alcohol, children's 0-5 services and sexual health services. For the major commissioning projects, development of commissioning intentions and arrangements for re-commissioning are well underway to ensure the transformation of services, in many cases through aligned commissioning and a move to a more whole systems approach. This supports the direction of travel with the Sustainability and Transformation Plan for Dorset.

7.2. There are however significant savings yet to be made. While the ring fence comes off…..

Agenda Item:

Insert Item No.

Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	21 November 2016
Officer	Chief Financial Officer and Director of Public Health
Subject of Report	**Financial Report on Public Health Grant: November 2016**
Executive Summary	The revenue budget for Public Health Dorset in 2016/17 is £29.378M. This is based upon a Grant Allocation of £35.154M. This report contains an update on the outturn forecast for 2016/17 which currently stands at £1.529m underspent. The final outturn is likely to be lower given the delay in key projects coming on line, in particular Health Checks. It is suggested that the reserve and savings are considered as one and redistributed along previously agreed lines with oversight through the respective health & wellbeing boards. The details are in the recommendations section below.
Impact Assessment:	Equalities Impact Assessment: An equality impact assessment is carried out each year on the medium term financial strategy.
	Use of Evidence: This report has been compiled from the budget monitoring information provided within the Corporate Performance Monitoring Information (CPMI).
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as:

	Current Risk: MEDIUM Residual Risk LOW As all authorities financial performance continues to be monitored against a backdrop of reducing funding and continuing austerity. Failure to manage within the current year's budget not only impacts on reserves and general balances of the three local authorities but also has knock-on effects for the Medium Term Financial Plan and puts future service provision at risk.
	Other Implications: As noted in the report
Recommendation	The Joint Board is asked to consider the information in this report and to: (i) Note the current and projected budget out-turn position; (ii) Note the value for money of public health spend in achieving national outcomes (iii) Agree that from the accumulated reserve and savings in 2016/17, totalling approximately £3.5m, the Board: • invest £0.4m in further expansion of the Livewell Dorset scheme to include expanding services for other age groups with an improved digital process for all potential service users. • invest £0.2m in improving analysis and modelling of patient flow and resource out of hospital care system to better understand the impact of any changes in the system. • invest £0.4m in developing services in localities, particularly around improving the engagement of patients and service users by training colleagues from the community and voluntary sector to better signpost people in need of care away from high cost acute services and statutory social care services. • Redistribute the remaining £2.5m to the three local authorities by the usual formula for their investment in early years' and health protection services. • Agree any further savings in 16/17 and 17/18 are redistributed based on discussion at the JPHB. • Agree that the respective Health & Wellbeing boards will provide oversight to ensure alignment with the respective health & wellbeing strategies.
Reason for Recommendation	Close monitoring of the budget position is an essential requirement to ensure that money and resources are used efficiently and effectively.

Appendices	Appendix 1 – Public Health Grant & Budget 2016/17
Background Papers	CPMI – October 2016/17 and Public Health Agreement
Report Originator and Contact	Name: David Phillips, Director of Public Health Tel: 01305-225868 Email: d.phillips@dorsetcc.gov.uk

1. Background

1.1 The Health and Social Care Act 2012 established new statutory arrangements for Public Health which came into effect on April 2013. This includes the creation of a new body responsible for Public Health at national level – Public Health England and the transfer of significant responsibilities to local councils from the NHS. NHS England and Clinical Commissioning Groups have some continuing responsibilities for public health functions.

1.2 The nationally mandated goals of public health in local authorities are to:

- Improve the health and wellbeing of local populations;
- Carry out health protection and health improvement functions delegated from the Secretary of State;
- Reduce health inequalities across the life course, including within hard to reach groups;
- Ensure the provision of population healthcare advice.

1.3 The agreed aims which underpin the work of Public Health Dorset are to:

- Address Inequalities;
- Deliver mandatory and core Public Health programmes in an equitable, effective and efficient manner;
- Improve local and national priority public health outcomes as defined by the Health and Wellbeing strategy and national Public Health Outcomes Framework;
- Transform existing programmes and approaches to population health to include better coordination of action across and within all public service agencies.

1.4 The agreed principles underpinning our commissioning to deliver the above aims are improving effectiveness, efficiency and equity. This has been reflected in our on-going re-procurement and overall work-plan to date.

1.5 At the last board meeting in September 2016 we discussed how, with the finalisation of many contracts, costs, and processes for the next couple of years it was possible to relook at how we might redistribute savings [reserve and 16/17 & 17/18]. We discussed a number of options but agreed we needed further discussion in particular with section 151 officers to ensure that any proposals supported common goals.

1.6 In the Board discussion we recognised the various factors and tensions that came into play, and while the importance of maintaining an effective spend in support of mandatory programmes was central, this needed, in several instances, to be seen in light of other local authority programmes, contributing to a common outcome.

1.7 We also looked ahead to the removal of the ring fence in April 2018 and the cessation of the public health grant in 2020. This paper expands the previous board discussions and in doing proposes some specific steps to deploy the public health grant to optimum benefit for the population.

2. Public Health Grant 2013-2020

2.1 At the last board meeting we discussed options as to the use of the savings and reserve and it was decided that this needed further discussion with a variety of people including the two section 151 officers. As part of the discussion with officers, it was felt that it is important to have some more understanding of the history and future of the grant. To that end we will look at:

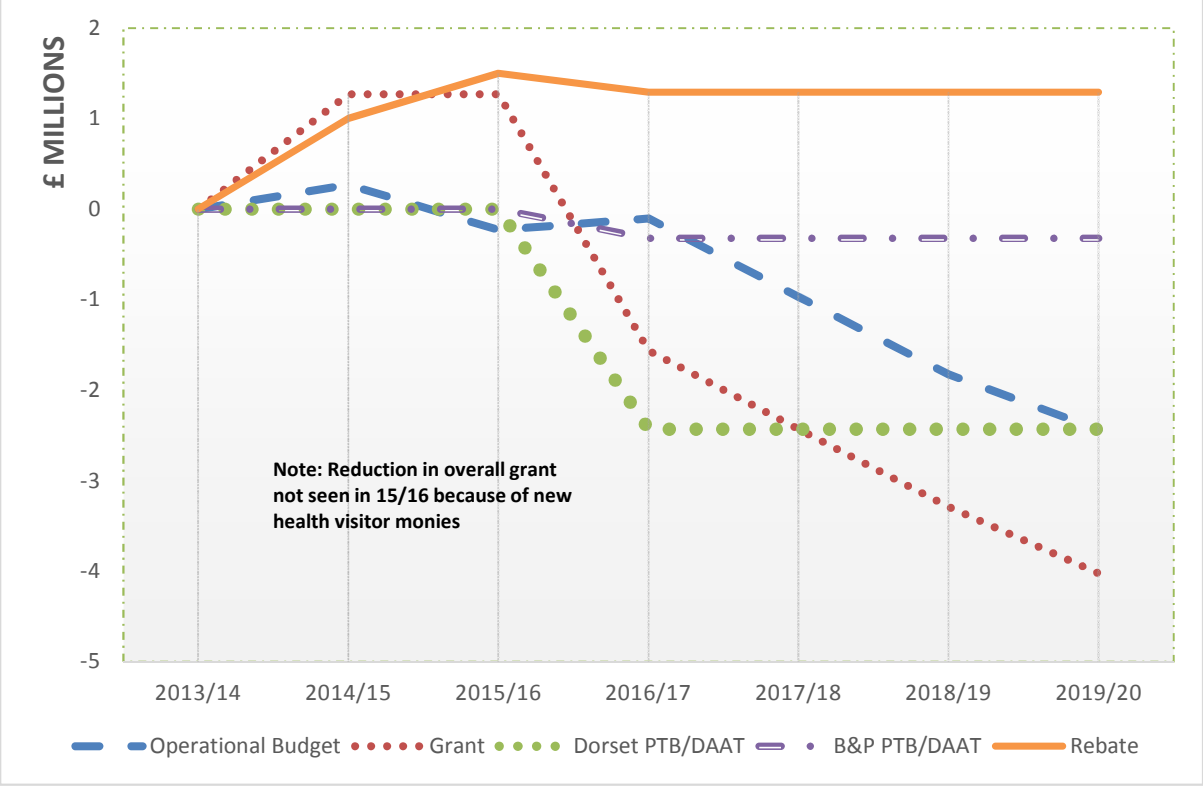
a. The history of the overall grant including future projection;

b. Changes in the grant's core elements;

c. The spend by authority on public health compared with other authorities and value for money considerations.

2.2 Table one describes the sums received and sums spent and savings made since 2013 projected to 2020 by major budgets lines. The changes in the grant in 2014/15 and 2015/1616 reflected the transfer of health visiting to local authorities. The overall grant rose for the first two years and is now on a steady decline equating to approximately 20% reduction in real terms by 2020

Table One: Public Health Grant 2013 – 2020 by Major Budget Lines

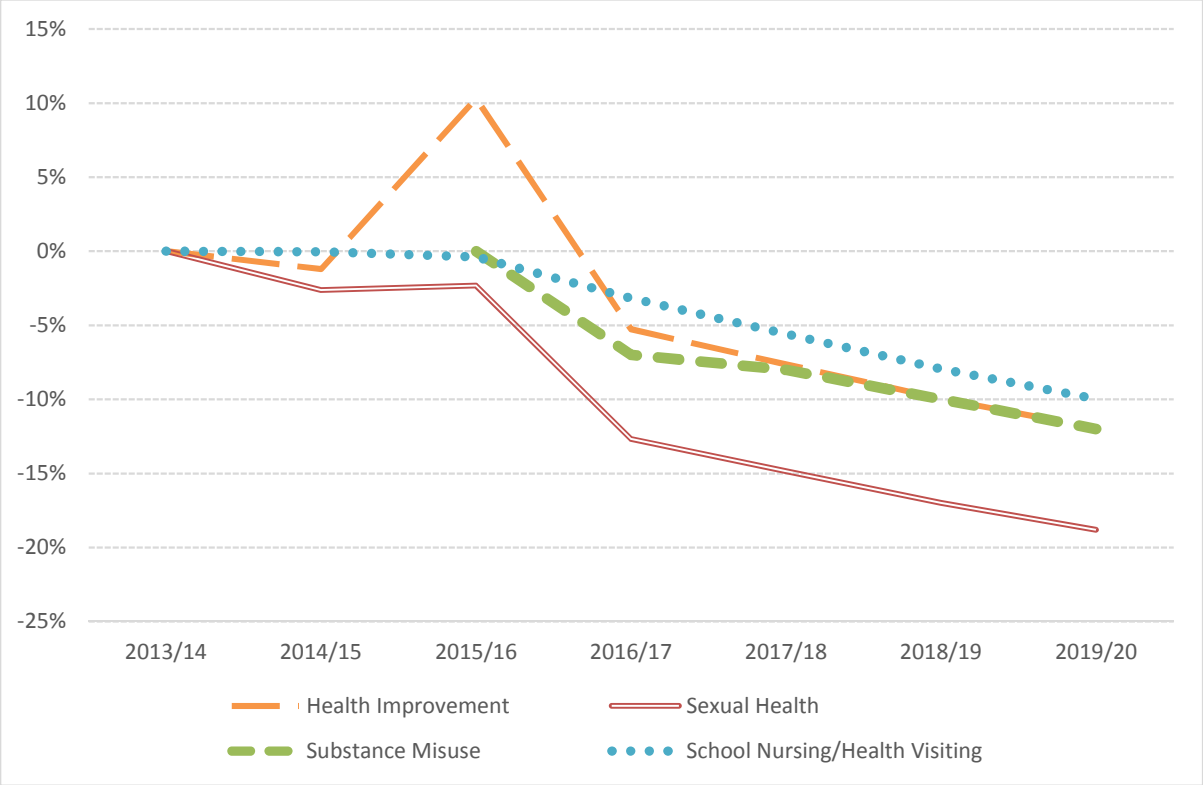


2.3 To date all the decline has been absorbed by reductions in the operating budget for mandatory services, retained (i.e. PTB/DAAT) and rebated monies have been left untouched.

2.4 These reductions in operating budgets have been made through a combination of both contract and efficiency/effectiveness measures. The pooling of the respective LA grants has been central to the ability to do this.

2.5 93% of the budget goes on front line services and of the remaining 7%, 4% goes on salaries for PHD staff and 3% on hosting charges for all three authorities. Table two shows a similar pattern for all the major programme areas, reflecting the reduction in grant in table one. The increase in health improvement reflected the investment from reserves in Livewell.

Table Two: Public Health Outturn by Major Programme Areas (% change from 2013)



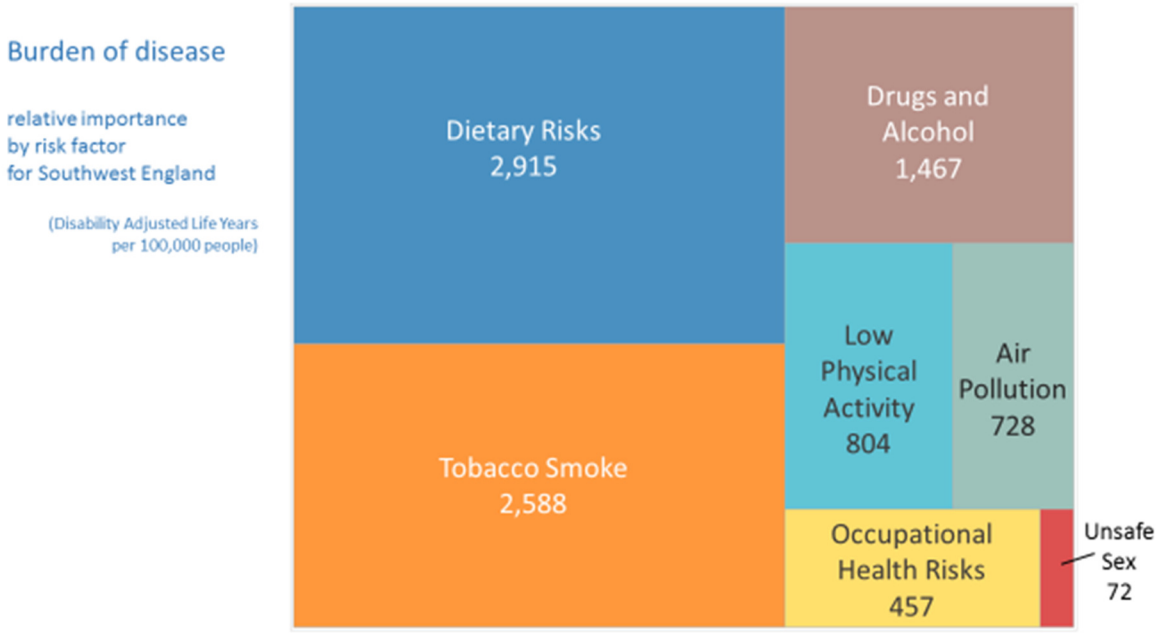
April 2018 - 2020

2.6 The ring fence will be removed in 2018 - we await the conditions around this. However it is highly unlikely that there will be removal of the statutory responsibilities in respect of both inequalities and mandatory programmes. As such it is unlikely that this will provide a significant opportunity for further savings or alternative reinvestment beyond those already flagged in other board papers.

2.7 More generally the public health grant is also projected to end in its current form in 2020/21. The current government position is that funding of local public health responsibilities will need to be out of business rates. It is the view of many that this will be a difficult positon to hold in the light of the future funding pressures on local government, and as such we need to look how we embed public/population health gain within broader plans and processes. This is already under way and we have many good examples at a local level, including the prevention at scale programme in the STP.

2.8 Figure one below illustrates how an understanding of the contribution of differing risks within a population to the burden of ill-health might inform a discussion of where to spend limited resources for population health gain as we go forward.

Figure One:

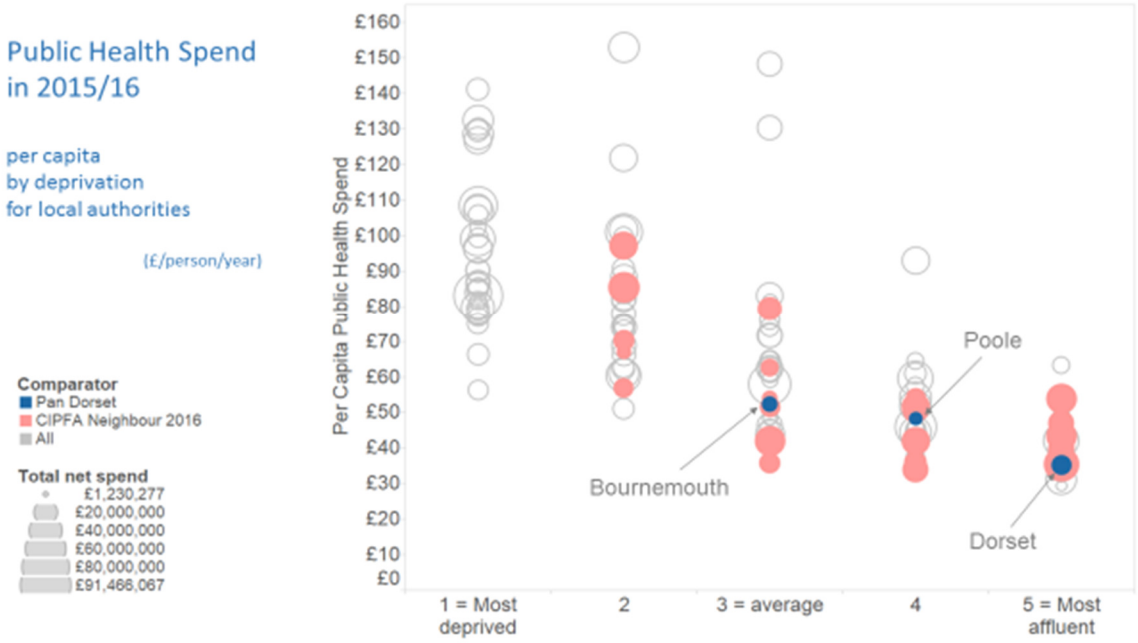


2.9 If we combine this information with an understanding of where we currently spend money and the relative return on investment on this spend, which is illustrated in figure two below, we can make better informed choices as to where to spend increasingly small budgets to best effect..

Figure Two:

Value for Money

Table Three: Per Capita Spend: LA v Deprivation v CIPFA neighbours



2.9 Table three shows that the per capita public health grant varies from £25/head to £155/head across England. Dorset is at £27/head, Poole at £43/head and Bournemouth at £50/head. These reflect historical spends inherited from the NHS. In relation to CIPFA neighbours the Dorset spend is in the bottom 5%, Poole top 40% and Bournemouth bottom 40%.

2.10 Tables four, five and six show the per capita spend per head on public health v outcomes by respective local authority by comparison with CIPFA neighbours and within authorities by comparison with other services.

2.11 It shows that all three authorities 'spend v outcome' for public health is positive being in the lower spend: better outcome quadrant and that in all instances it compares positively with the same ratio for other local authority services.

Table Four:

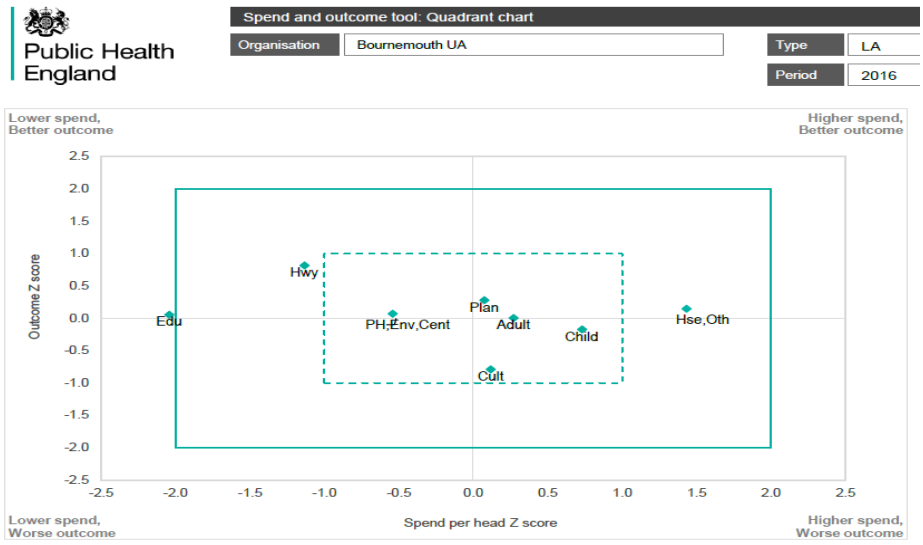
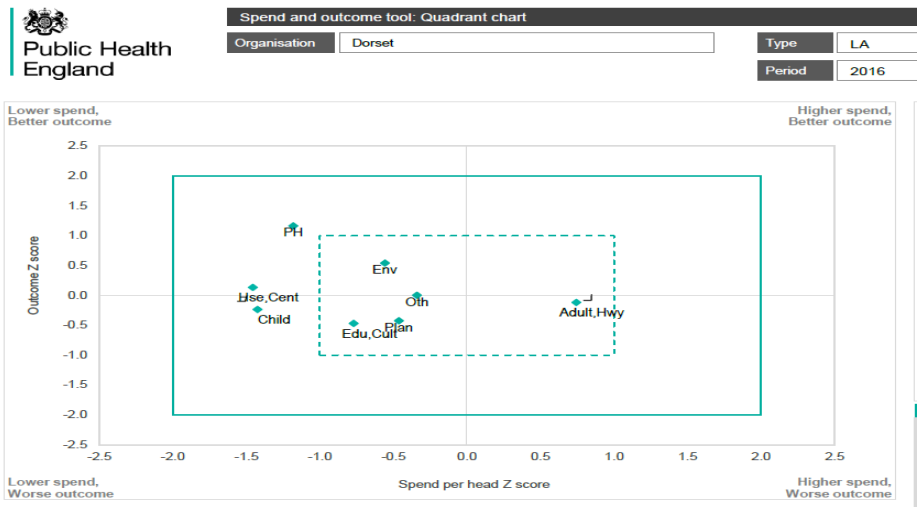


Table Five:

Table Six:



3. Use of Reserve and Savings

3.1 Subsequent to the last board meeting further discussions were held with key individuals in all three authorities and Public Health Dorset including the two Section 151 officers and it was agreed that savings for 16/17 and the reserve would be treated as a whole and allocated as follows:

a. £2.5m to be returned to the respective authorities by the agreed formula as per the decision made at the previous Board meetings, namely to support 'early years and health protection'.

Rationale: One of the criteria for spend of the public health grant requires investment in 'high value' activities and those with a clear link to existing public health outcomes. A sustainable and comprehensive early years programme is a good example as it is essential to not only addressing inequalities but also key to supporting a major element of the grant spend, i.e. health visiting and school nursing, and the transformation of such work.

The pressures in the early years area are such that if only mandatory (e.g. safeguarding functions or services to high risk populations) are provided and more comprehensive approaches to prevention are not funded, there will be a rapid erosion of outcomes in young children, which will feed into the need for high cost 'care' services.

b. £1.0m be retained by PHD to invest in support to three areas that are central underpinnings of all outcomes and priorities, these are:

- *Livewell:*
  It is proposed to invest approx. £400k in Livewell our established behaviour change service to develop the infrastructure to enable it to become a robust behaviour change platform for a larger cross section groups of people and organisations.

  Rationale:
  Effectively promoting behaviour change is recognised as central to managing demand in in a wide variety of services. The Livewell project has clearly demonstrated its effectiveness and has been recognised nationally. However, to date investment has been limited until we were clear that it was a cost effective model. We now have the information to expand the model.

- *Intelligence Capacity*:
  It is proposed to invest approx. £200k in intelligence capability primarily to better analyse/understand activity, costs and benefits at the interface between the health and social care system, including the impact of any changes in the system.

  Rationale:
  A far better understanding of the real costs and benefits of various current areas of focus, e.g. delayed transfer of care and courses of action is vital, especially going forward. This is of particular importance given the current focus of the STP on financial balance for the system.

- *Improving Capacity in Localities for Demand Management*

  In addition it is proposed to invest up to £400k to train and support Patient and Public Involvement Groups in primary care across the 13 Localities in Dorset to be able to develop their own networks of voluntary sector support over a two year period.

  Rationale:
  This will help with the development of integrated locality teams, particularly improving the engagement of patients and service users by training people from the community and voluntary sector who will be able to better signpost people in need of care. This has been shown to be effective in improving outcomes among people living with long term conditions. This links to existing local authority and voluntary networks.

  This also maintains independence and resilience of people in their own homes and reduces demand on formal services, particularly high cost acute services and statutory social care services

3.2 All three elements build on existing capability with the express intent of managing demand through the use of better intelligence, better behaviour change programmes and better community engagement. These criteria are established as being key to any transformation programme, such as the STP (Kings Fund 2015).

3.3 It was the view of all parties that this was not only consistent with the grant criteria but an efficient and equitable use of funds to support core outcomes within the public health outcomes framework and to support the more general statutory responsibility of authorities to reduce inequalities.

3.4 The total sum of £3.5m should also be overseen by the respective health and wellbeing boards to ensure alignment with the health and well-being, and related, strategies. It is proposed that any additional savings in 16/17 and 17/18 are divided up based on discussion at the Board. To maximise the savings it will be important to maintain pooling of the PH grant.

4. Public Health Grant: 2016/17 Forecast Outturn & Reserves

4.1 The Public Health Budget is forecast to be underspent by £1.529m at the end of 2016/17. This out-turn figure is a straight line extrapolation of existing spend patterns and is likely to be significantly lower as some costs have been delayed to the second half of the year due to delays in signing contracts in particular Health Checks. The update positon of the reserve is £2.35m. This will not affect the sums discussed for reallocation above. If the savings are less then the PHD investment will be scaled back appropriately. The budget details are in appendices one, two and three.

5. Conclusion

5.1 Public Health Dorset recognising the budget challenges both to the central public health grant and the wider local authority budgets has worked to ensure further savings. It is proposed that we redeploy all savings [including reserves] to build resilience in the overall services and systems that work together for population health gain.

5.2 We have specific proposals to redeploy £2.5m back to local authorities on the usual formula and invest £1.0m in core infrastructure for future joint working.

5.3 It should also be recognised that collectively we remain amongst the bottom 10% of funding per head of population of all local authorities. These further savings and data shown in the paper illustrate our continuing delivery of value for money.

Richard Bates
Chief Financial Officer
November 2016

Dr David Phillips
Director of Public Health

APPENDIX 1

Public Health Budget 2016/17 and Forecast Outturn

2016/17	Budget 2016-2017	Outturn 2016-2017	Underspend 2016/17
Public Health Function			
Clinical Treatment Services	£11,464,100	£11,010,650	£453,450
Early Intervention 0-19	£11,575,500	£11,314,594	£260,906
Health Improvement	£2,984,700	£2,462,546	£522,154
Health Protection	£145,000	£54,000	£91,000
Public Health Intelligence	£244,800	£264,772	-£19,972
Resilience and Inequalities	£175,000	£75,000	£100,000
Public Health Team	£2,786,300	£2,664,799	£121,501
Total	**£29,375,400**	**£27,846,361**	**£1,529,039**

APPENDIX TWO

Public Health Reserves at November 2016

Public Health Reserve	£000's
Public Health Underspend 2013/14	1,447
DAAT Underspend 2013/14 one off (DCC)	111
PTB Underspend 2013/14 one off (DCC)	177
Use of 2013/14 underspend Poole	(287)
Use of 2013/14 underspend Bournemouth	(356)
Use of 2013/14 underspend Dorset	(700)
Public Health Underspend 2014/15	1,381
PTB Underspend 2014/15 one off (DCC)	20
Public Health Underspend 2014/15	564
Total	**2,350**

APPENDIX 3

Public Health Grant And Budget (by Local Authority) – 2016/17

	Poole	Bmth	Dorset	Total
	£000's	£000's	£000's	£000's
2016/17 Grant Allocation	7,991	11,051	16,112	35,154
Less Commisioning Costs	(30)	(30)	(30)	(90)
Less Pooled Treatment Budget and DAAT Team costs	(1,300)	(2,925)	(170)	(4,395)
Public Health Increase back to Councils	(299)	(371)	(621)	(1,291)
Joint Service Budget Partner Contributions	**6,362**	**7,725**	**15,291**	**29,378**
Budget 2016/17	**6,362**	**7,725**	**15,291**	**29,378**

Agenda Item 10

Public Health Dorset

Agenda Item:

Insert Item No.

Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	21 November 2016
Officer	Director of Public Health
Subject of Report	**Integrated Community Services**
Executive Summary	Developing integrated community services is a core part of the Sustainability and Transformation Plan for Dorset. This report presents a briefing for board members on the current plans, progress and potential opportunities for improving prevention and population health from improving community services. Above all, it sets out how getting integration right in localities could form the foundation for a place-based approach to health and wellbeing.
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: N/A
	Use of Evidence: Public Health Dorset routinely uses a range of evidence to support the development of business plans and priorities as part of its core business.
	Budget: There are no direct public health grant implications arising from this briefing. However, integration of community services is a part of the overall drive to reduce use of hospital services and improve the ability to deliver care close to home. This has budget implications

	for the organisations committed to implementing the Sustainability and Transformation Plan for Dorset, including local authorities.
	Risk Assessment: N/A
	Other Implications: N/A
Recommendations	1) Members of the Joint Public Health Board are asked to note and comment on the briefing on integrated community services development, and implications for moving to a more place-based model of care.
Reason for Recommendation	To ensure Board Members are aware of plans for community services within the Sustainability and Transformation Plan that could help deliver a place-based and more preventive approach to health and care in Dorset.
Appendices	
Background Papers	None.
Report Originator and Contact	Name: Sam Crowe Tel: 01305-225884 Email: s.crowe@dorsetcc.gov.uk

Director's name: Dr David Phillips
Director of Public Health
November 2016

1. Recommendations

1. Members of the Joint Public Health Board are asked to note and comment on the briefing on integrated community services development, and implications and opportunities for moving to a more place-based model of care.

2. Reason

2.1 To ensure Board Members are aware of plans for community services within the Sustainability and Transformation Plan that could help deliver a place-based and more preventive approach to health and care in Dorset.

3. Background

3.1 The development of integrated community services is an important part of the Sustainability and Transformation Plan for Dorset. The essential idea is that more people's health and care needs will be met outside of hospital by larger, more integrated teams of professionals working across organizations, focusing on people's needs and helping them to better manage their conditions.

3.2 However, this apparently simple concept is by no means simple to implement, because of the way that community services are currently configured, paid for, and used. The NHS has traditionally been good at developing highly specialized clinical roles, even among community nursing staff. When coupled with delivery of very specific pathways of clinical support, usually focused on a single condition e.g diabetes, this results in care processes that can appear to the individual receiving them as fragmented, inefficient and confusing.

3.3 Integration is a concept intended to overcome some of these limitations to the current, community services model. While there are many different models described in the literature, at the heart of most of the models is the idea that it is about better co-ordinated care for people living with chronic conditions, more often than not delivered in community settings and people's homes, with the aim of reducing use of secondary care services and improving health outcomes of individuals.

3.4 There are also some other important elements to integrated care programmes that could present important opportunities in Dorset, particularly the links with taking a more preventive approach to health and care, and considering the needs of populations living in a particular place. Many earlier ideas about integrated care involved ideas about measuring likelihood of hospital admission, and attempting to reduce this likelihood by focusing preventive services on the people at highest risk of admission. These ideas have been developed further by The King's Fund, which now talks about population-based approaches to health and care, looking at the needs of the whole population, not just those with the highest health and care needs[1]. This also considers the importance of wider determinants of health on the population's health and wellbeing.

3.5 So a truly population-based system of care going beyond just integration would:

- Consider the whole population's health and wellbeing needs and ensure that incentives are aligned to support improving outcomes for whole populations, including across organizations and budgets;

- Be able to offer consistent, early, evidence-based support for prevention interventions before the development of chronic diseases, including social interventions such as housing improvements; [note: this can be delivered to targeted sub-groups of populations];

- Think not just about integration of community health professionals, but integration of approaches to health that go beyond individual interventions; such as environments that promote physical activity, access to green space, higher value jobs, access to quality relevant education. This could also include consideration of the importance of integration across age groups, e.g. between adults and children's services, for example.

4. Integration in the Sustainability and Transformation Plan

[1] Population health systems: going beyond integrated care. London, Kings Fund, February 2015.

4.1 The Sustainability and Transformation Plan "Our Dorset" recognises the importance of integrated community services, and it is described within the plan as the second of three principal programmes (along with Prevention at Scale, and One Acute Network).

4.2 The stated ambition is to 'transform primary, community and care services in Dorset sot that they provide integrated care, based on the needs of different local populations'. There is an ambitious intention that this transformation will help to reduce outpatient attendances by 10 per cent, follow up appointments by 25%, and emergency medical and surgical admissions by 25 and 20 per cent respectively.

4.3 The plan envisages creating a network of community hubs across Dorset, from which teams of mixed professionals will provide care for people with physical and mental health needs. The hubs will cater for children, adults and the growing elderly population.

4.4 Each of the hubs will provide a range of health and care services, ranging from routine care (e.g. general practice and preventive services such as screening, immunisations, elements of health visiting), to diagnostics and access to secondary care specialists via outpatient clinics, consultations and some minor procedures. The hubs will also provide access to urgent care services, aiming to prevent admission to hospital for a substantial number of people who currently cannot be supported outside of hospital.

4.5 Proposals for the location of the community hubs are being developed for consultation. It is likely that in the urban areas of Bournemouth and Poole, the community hub will be located at whichever hospital becomes the major planned site. In other areas of Dorset, the existing community hospitals are likely to be reviewed for suitability to become the sites for the new hub arrangements.

4.6 A crucial part of the development of integrated community care is modernising general practice, in line with the GP Forward View[i2]. This set out ideas about new models of general practice, to address some of the current national challenges around workforce, demand, morale, efficiency and back office services, including identifying new ways of offering primary care working more closely with community health services and others in extended multi-disciplinary teams.

5. Progress to date

5.1 There has been good progress in developing new ways of integrated working in communities, with health visiting and school nursing commissioning projects that will see delivery of the services as part of the wider set of integrated services for children and young people. Already, health visitors across Dorset are working more closely than ever before with children's centres, bringing them closer to other professionals supporting children and families in the community. For adults, the Better Together Partnership (Better Care Fund) has supported the development of integrated locality teams comprising health and social care professionals in the 13 Dorset localities. These teams support early discharge from hospital, rehabilitation and recovery for patients with conditions like stroke, and better end of life care. However, to date they have not made an impact on reducing emergency admissions to hospital.

5.2 Public Health Dorset has been involved in the past year in developing new models of care to support the transformation of primary care and community services, as part of the Dorset Vanguard programme. This work is now being extended with support from the Wessex Transformation Fund to enable general practices in North Bournemouth to

[2] NHS England April 2016. General Practice Forward View. See https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

work more closely together and implement the new model of care. Current pressures in general practice are limiting the pace at which transformation can take place, with many working flat out just to meet current demand.

5.3 Finally, the Dorset CCG has been working on a new primary care strategy to support the transformation of primary care, required as part of the development of integrated community services. There is still the need for more detail around the mechanisms through which the CCG will shape future models of primary care, for example, reducing the number of GP surgeries, and supporting new models of care as set out in the GP Forward View.

6. Potential opportunities

6.1 The integrated community services programme of the STP offers the opportunity of moving to a more place-based view of how best to organise the resources to meet the needs of populations across Dorset. This is in contrast to the current way that services are often organised, based on provider and organisation needs. This place-based view includes looking at how the total health and social care resources should be deployed around the person, not managed within organisational silos.

6.2 The transformation of primary care is a key part of ensuring an effective approach to improving outcomes for populations. For too long, there has been a push / pull on community teams like district nurses and health visitors – arguments over whether they work attached to primary care practices for example, or based in community teams.

6.3 There is an opportunity to explore new models of primary care that would see general practice as just one element of an integrated community-led model of care. Where this has worked well elsewhere, GPs are an integral part of a much more holistic model of care, often incorporating not just professionals but peer supporters and voluntary sector organisations. These people are often better placed to deal with some of the more complex social issues connected with primary care presentation.

6.4 Another aspect of ICS work is that it has the potential to address the current challenges around variation in quality of care and outcomes for people with long-term conditions like diabetes. If networks of practices established support at scale for people in whole localities living with diabetes, involving a variety of care and support planning approaches, it would improve efficiency and outcomes based on experience from elsewhere in England (Tower Hamlets and Sefton, for example).

6.5 There is also the chance within this work stream to change the culture of how community services teams work. Traditionally, resources like district nursing have been managed on a task focused basis – nurses have a case list and tend to work through the list according to tasks that need doing e.g. dressings that need changing etc. There is growing interest in different nursing care models that allow teams of nurses to determine for a particular area what the care needs and priorities should be. This model, known as Buurtzorg after the Dutch integrated nursing care organisation that first developed it[3] – has been shown to lower costs and substantially increase the satisfaction of people being cared for in evaluations so far. Public Health Dorset is working with Bournemouth University and Dorset Healthcare University Foundation Trust to see if a pilot study can be started within Dorset to test out this approach with a view to evaluating the potential for implementing at scale.

[3] Royal College of Nursing. The Buurtzorg Nederland Home Care Nursing model. See https://www2.rcn.org.uk/__data/assets/pdf_file/0003/618231/02.15-The-Buurtzorg-Nederland-home-care-provider-model.-Observations-for-the-UK.pdf

7. Questions for the Board to consider

7.1 The following questions may be helpful for Board Members to bear in mind in future discussions and debates around how ICS is developing within the STP, including for example at Health and Wellbeing Boards.

Will integrated community services plans in the STP:

- Help to deliver the challenges identified by the Prevention at Scale programme, particularly reducing the observed variation in secondary prevention for people with established conditions like cardiovascular disease?
- Improve the use of information – both on a personal level through better shared records, and at population level, to ensure interventions consider the needs of all the population, not just those presenting most acutely?
- Enable community teams to work more upstream and prevent demand and costs in secondary care?
- Reduce overall use of secondary care – emergency admissions, outpatient attendances and follow up appointments?
- Close the health and wellbeing gap, in line with the Five Year Forward View?
- Deliver against the particular needs of communities that differ across Dorset?
- Keep community staff motivated, engaged and enable better retention of staff, particularly those working in primary care?
- Ensure that the planned reduction of secondary care use including emergency admissions does not involve cost shifting to other teams, such as adult social care?
- What are the cultural obstacles to this 'working together' given it has been spoken about for many years but there is little evidence of it happening and what can board members do in the localities to change that culture?

8. Conclusion

8.1. This briefing has been written to help raise Board Members' awareness of the current plans to deliver integrated community services within the STP. This is because there are huge potential opportunities to help resolve some of the challenges identified by the Prevention at Scale programme, not least improving peer and personalised care and support planning for people with chronic disease, and scaling up information-driven disease management through developing transformed primary care.

Sam Crowe
Deputy Director of Public Health
4 November 2016